

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial/transit permit. Then please remove carbon patient page and attach to the burial/transit permit. This form is to be used in accordance with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked, or Item 18 shows any injury, or other traumatic event,

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
8 0 2 3 0 9 7 REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	
Mary Mildred Blair						8 11 86			8	11	86	
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			2b. HOUR		
Female			White	MONTH	DAY	YEAR	XX 85 84 yrs.			125 AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
St. Mary's County			U.S.A.						Charles			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
LaPlata			Meridian Nursing Home						20609			
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Maryland			St. Mary's			Avenue			General Delivery			
FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
DeSales Cleveland Bailey			Sarah Madeline Woodburn									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS						
No			219-48-5769			Mary Frances Tippett Avenue, Md.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer Colon</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. 19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from <u>5-57</u> , 19 <u>86</u> , to <u>8-11</u> , 19 <u>86</u> , that (1) (we) last saw the deceased alive on <u>6-8</u> , 19 <u>86</u> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated												
22b. SIGNATURE <u>Bertha</u>			DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8-11-86</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial			8/14/86			Sacred Heart Cemetery			Bushwood St. Marys Md.			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley Leonardtown, Md.						AUG 14 1986						

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00-168521-

23098

REG. NO.

FOR
STATE
REGISTRAR
1. DECEASED NAME FIRST MIDDLE LAST
(TYPE OR PRINT) **Arthur WILLIAM Bottenfield**
2. DATE KNOWN
OF
ESTI-
DEATH
MATED
 8 28 1986 8 25 PM
3. SEX M RACE W 3. DATE OF BIRTH MONTH DAY YEAR 4. AGE (IN YEARS LAST BIRTHDAY)
MONTH DAY YEAR 53 YRS.
5. IF UNDER 1 YR. 6. IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

2a. DATE
MONTH DAY YEAR
2b. HOUR
 8 28 1986 8 25 PM
2c. DATE
MONTH DAY YEAR
2d. HOUR
 8 28 1986 8 25 PM

9. BALTIMORE CITY OR COUNTY OF DEATH
Charles County,

10. CITY OR TOWN OF DEATH
Nanjemoy

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
RT. 1, Box 212 A 20662

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
General Contractor

12b. KIND OF BUSINESS
CONSTRUCTION

13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland

13b. COUNTY
Charles

13c. CITY OR TOWN
Nanjemoy

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS
Route #1, Box 212 A

Zip 20662

14. FATHER'S NAME

FIRST MIDDLE LAST
Emory Thompson Bottenfield

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST
Margaret Lou Griffin

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) 1952-1956

16b. SOCIAL SECURITY NO.
228-42-2024

17. PLACEMAN ADDRESS
7014 Woodside Drive, Lanham, Md. 20706

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **cardio respiratory arrest**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

Minutes

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS
UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)

21d. INJURY OCCURRED
WHILE NOT WHILE
AT WORK AT WORK

21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

21f. LOCATION
STREET CITY OR TOWN COUNTY STATE

22a. I certify that I took charge of the remains described above, held on
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner

Autopsy Inspection Inquiry and in my opinion

ACTUAL
SIGNATURE

H. Mahan Haft

M.D. **Charles Co** MEDICAL EXAMINER

DATE
SIGNED

8/29/86

EXAMINER'S NAME
(TYPE OR PRINT)

H. Mahan Haft MD

ADDRESS **SR#1 Box 1020 La Plata, Md. 20646**

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation

23b. DATE
8/30/86

23c. NAME OF CEMETERY OR CREMATORIAL
Lee Crematory

23d. LOCATION
CITY OR TOWN
Clinton, Maryland COUNTY STATE

24. FUNERAL DIRECTOR

NAME **Arehart Funeral Home, Inc., La Plata, Md.**

ADDRESS **SR#1 Box 1020 La Plata, Md. 20646**

25a. DATE REC'D. BY REGISTRAR
25b. REGISTRAR'S SIGNATURE

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE GIFT 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH GIFT 3. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1AND 2 SHOULD BE USED AS A BURIAL, CREMATION, OR REMOVAL AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

00-16625

One hour

1000-1000

1000-1000

00-15624

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use on the burial/transe granite. Then please remove carbon paper. Page 1 should be held within 72 hours after death and sent with the State Dept. of Health and Mental Hygiene prior to burial, interment, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, an other traumatic event, the medical certifying physician must be notified at once.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

6 2 3 0 9 9

REG. NO.

1. DECEASED NAME <small>(TYPE OR PRINT)</small>			FIRST ANNA	MIDDLE MARGARET	LAST BOWIE	2a DATE OF DEATH 8-16-86	MONTH 8	DAY 16	YEAR 86	2b HOUR 2:30 P.M.	
3. SEX Female			4 RACE White	5. DATE OF BIRTH MONTH 06			DAY 06	YEAR 23	6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA			7b. CITIZEN OF WHAT COUNTRY? U.S. OF A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED XX DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES COUNTY, MD.		
10. CITY OR TOWN OF DEATH POTOMAC HEIGHTS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 14 JONQUIL PLACE (20640)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER			12b. KIND OF BUSINESS OR INDUSTRY AT HOME		
13a. STATE MARYLAND			13b. COUNTY CHARLES	13c. CITY OR TOWN NANJEMOY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO XX			13e. STREET ADDRESS ROUTE 1 BOX 142 20662			
14. FATHER'S NAME FIRST MINOR			MIDDLE 	LAST DODSON	15. MOTHER'S MAIDEN NAME FIRST ELLA			MIDDLE 	LAST TUCKER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT MARGARET L. COLLINS, POTOMAC HGTS., MD.			ADDRESS 14 JONQUIL PLACE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE RESPIRATORY ARREST									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DOUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF LUNG								
			DOUE TO, OR AS A CONSEQUENCE OF (c) CHRONIC OBST. PUL. DISEASE								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 7-1-86 , 19_____, to 8-16-86 , 19_____, that (I) (we) lost saw the deceased alive on 8-11-86 , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Krishan M. Mathur</i>		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 8-16-86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KRISHAN M. MATHUR		22e. ADDRESS 17 MARSHALL Rd WALDORF MD 20601									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 08/19/86		23c. NAME OF CEMETERY OR CREMATORIAL NANJEMOY BAPTIST		23d. LOCATION CITY OR TOWN NANJEMOY			COUNTY CHARLES	STATE MD.	
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC., LA PLATA, MD.		25a. DATE REC'D. BY REGISTRAR AUG 19 1986			25b. REGISTRAR'S SIGNATURE <i>Jane Anderson Pendleton</i>						

TO HOSPITAL OR ATTENDING PHYSICIAN

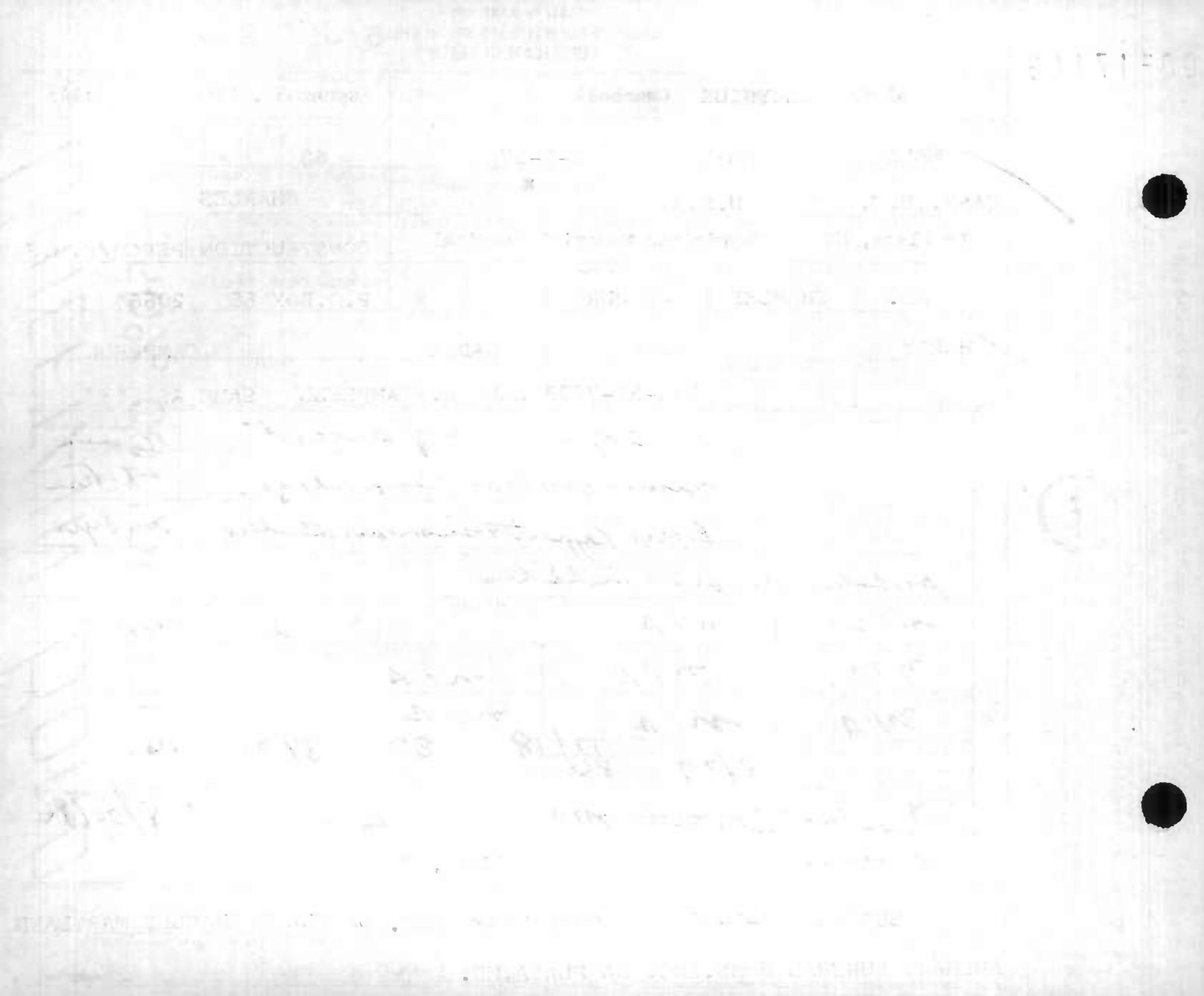
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transcript. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23100

REG NO

1. DECEASED NAME (TYPE OR PRINT) Calvin ALOYSIUS Campbell			MIDDLE	LAST	2a. DATE OF DEATH August 30, 1986	MONTH	DAY	YEAR	2b. HOUR 2:14a M
3. SEX MALE	4 RACE BLACK	5. DATE OF BIRTH MONTH 9-2-37	YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 48	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH., D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES MD.				
10. CITY OR TOWN OF DEATH La Plata, MD	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION					12b. KIND OF BUSINESS OR INDUSTRY PEPCO/F.B.I.JOY
13a. STATE MD.	13b. COUNTY CHARLES	13c. CITY OR TOWN NEWBURG	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE P.O. BOX 65 20664					
14. FATHER'S NAME FIRST HARRY	MIDDLE	LAST BROWN	15. MOTHER'S MAIDEN NAME FIRST SADIE	MIDDLE	LAST CAMPBELL	ADDRESS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 214-32-7593	17. INFORMANT ELLA E. CAMPBELL	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 min						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Cardiopulmonary arrest						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) massive cerebral hemorrhage						
			DUE TO, OR AS A CONSEQUENCE OF (c) severe hypertension uncontrolled						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) probable Diabetes mellitus									
19a. DATE OF OPERATION n/a	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED n/a	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) n/a	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. n/a 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) n/a							
21d. INJURY OCCURRED WHITE <input type="checkbox"/> BLACK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) n/a	21f. LOCATION CITY OR TOWN n/a	CITY OR TOWN COUNTY STATE						
22. I certify that (I) (this hospital) attended the deceased from 12/18 , 19 80 , to 8/30 , 19 86 , that (I) (we) last saw the deceased alive on 8/29 , 19 86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Paul Pritchett MD	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8/30/86				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Paul Pritchett	22e. ADDRESS La Plata, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 9-3-86	23c. NAME OF CEMETERY OR CREMATORIAL SACRED HEART CEM.	23d. LOCATION CITY OR TOWN LA PLATA	23e. COUNTY CHARLES	23f. STATE MARYLAND				
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC.	ADDRESS LA PLATA, MD.	25a. DATE REC'D. BY REGISTRAR 8/30/86	25b. REGISTRAR'S SIGNATURE AREHART FUNERAL HOME, INC.						



Items, 18a, 19b, & 22a, Med FOR STATE OF MARYLAND
 1- STATE G-620, / 10/1/86 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR Gb) MEDICAL EXAMINER'S CERTIFICATE OF DEATH

23101

REG. NO.

1 DECEASED NAME (TYPE OR PRINT)			PATRICIA LOUISE CHICK			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR			2b HOUR		
SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE IN YEARS LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR			2d HOUR		
Fe	Cau	Jan 31, 1959	27 yrs.			8-30-86 19			PM 10:58		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Wash., D.C.		USA						Charles County MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
LaPlata		Physicians Memorial Hospital			None			---			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS				
Maryland		Charles		Charlotte Hall		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rt-1 Box-107 /20622				
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
John Francis Chick Sr.		Dorothy Ann Hamilton									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-70-2654			17. INFORMANT John F. Chick			ADDRESS -Same as #13)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Seizure disorder DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)						DATE SIGNED 8-31-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/3/86			23c. NAME OF CEMETERY OR CREMATORIUM St. Mary's Cemetery			23d. LOCATION CITY OR TOWN Bryantown, Charles, Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS P. O. Box 156			25a. DATE REC'D. BY REGISTRAR Waldorf, Md 20601 SEP 3 1986			25b. REGISTRAR'S SIGNATURE			
Huntt Funeral Home											

1000 - 0

32100

as separate and
X

each other

reasons that the X had not been found in the

middle of the village. It was not in the center

of the town - but in the middle of the town.

The reason for this is that the town is very

old and has been built up over time.

The town is very old and has been built up

over time. The town is very old and has been

built up over time. The town is very old and

has been built up over time. The town is very

old and has been built up over time. The town

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is very old and has been built up over time.

The town is very old and has been built up

over time. The town is very old and has been

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 72 hours of the death. Page 4 may be required by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial/transit permit. Then please remove carbon paper. Pages 1, 3 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 6 2 3 1 0 2											
1. DECEASED NAME (TYPE OR PRINT)		RONALD <i>Ronald</i>		MIDDLE <i>Collinge</i>	COLLINGE <i>Collinge</i>		2a. DATE OF DEATH MONTH DAY YEAR		8-16-86		2b. HOUR 8:57 P.M.
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Nov 2, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR YRS.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles		MD.			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov					
13. STATE Maryland		14. COUNTY Charles	14c. CITY OR TOWN Cobb Island	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 83 W. Craine Blvd /20625					
14. FATHER'S NAME FIRST Godfrey		MIDDLE <i>Collinge</i>	LAST <i>Collinge</i>	15. MOTHER'S MAIDEN NAME FIRST Elizabeth		MIDDLE <i>Hazeltine</i>	LAST <i>Dobson</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-05-5993		17. INFORMANT Marie G. Collinge		ADDRESS -8ame as #13-					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE <i>Death by mechanical suffocation</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>			
DUE TO, OR AS A CONSEQUENCE OF <i>Death by mechanical suffocation</i>											
DUE TO, OR AS A CONSEQUENCE OF <i>Collusion</i>								<i>years</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED <i>While at work</i>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (this hospital) attended the deceased from 1-20 , 19 66 , to 8-16 , 19 86 , that (we) lost saw the deceased alive on 7-11 , 19 86 , and that (my) our opinion death occurred on the date and hour and from the causes stated above. (I/we) did (did not) view the body after death.											
22b. SIGNATURE <i>Richard H. Dobson, M.D.</i>		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN	22c. DATE SIGNED 8-16-86
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard H. Dobson, M.D.		22e. ADDRESS Brandywine, Maryland 20613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-20-86		23c. NAME OF CEMETERY OR CREMATORIUM Huntt Crematorium		23d. LOCATION CITY OR TOWN Waldorf, Charles, Md.		COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home		ADDRESS P. O. Box 156 Waldorf, Md. 20601		25a. DATE REC'D. BY REGISTRAR AUG 19 1986		25b. REGISTRAR'S SIGNATURE <i>John L. Dobson - M.D.</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 is marked or item 21 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 23183	
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR	
			DAVID ANTHONY Davis						08/14/86			5:20 P M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		08 14 86			MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTHS DAYS		HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8			9 BALTIMORE CITY OR COUNTY OF DEATH			Charles MD.			
MARYLAND		U. S. OF A.											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
La Plata			Physicians Memorial Hospital			INFANT			N/A				
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
MARYLAND			CHARLES		LA PLATA					P.O. BOX 127 20646			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
JEFFREY LEE DAVIS			DONNA LYNN SPALDING										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
NO			N/A			JEFFREY L. DAVIS, LA PLATA, MD. 20646			P.O. BOX 127				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Intravascular Respiratory System</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Immaturity</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Incongested Ovarine Cervix</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Pablo Dublin M.D.</i> DEGREE <i>M.D.</i>												22c. DATE SIGNED <i>8/16/86</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
Pablo Dublin M.D.			WaLdorF, Md 20601										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
BURIAL			08/18/86			SACRED HEART			LA PLATA CHARLES MD.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
AREHART FUNERAL HOME, INC., LA PLATA, MD.						AUG 19 1986			<i>Julia London, Rader</i>				

tains names of infants whose birth
ssed by the Division of Vital Records
nt birth certificates to DVR which are
evious list, please contact Ms. Faye
Ms. Marisa Wilson at 410-225-5937.

TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it may be used as the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the coroner after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

**1 - STATE
REGISTRAR**

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23104

REG NO

1. DECEASED NAME (TYPE OR PRINT) FERDINAND			FIRST MIDDLE N/M/N	LAST FEST Jr.			2d. DATE OF DEATH MONTH DAY YEAR 8-18-86	2b. HOUR 5:50 PM
3. SEX M	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 3 - 15 - 1913	6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE COUNTRY TEXAS	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles			MD.		
10. CITY OR TOWN OF DEATH White Plains	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 1, Box 240 Spring Valley			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Govt. Employee			12b. KIND OF BUSINESS OR INDUSTRY US Govt	
13a. STATE N.Y.	13b. COUNTY Charles	13c. CITY OR TOWN White Plains	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Rt 1-Box 240 Spring Valley Dr 20695				
14. FATHER'S NAME FIRST FERDINAND	MIDDLE FEST	15. MOTHER'S MAIDEN NAME FIRST LISBIE	MIDDLE L.	LAST SEYNER			ADDRESS Same as #13	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) ✓	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.II-1945 220-12-3858	17. INFORMANT DONNA				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Dementia { DUE TO, OR AS A CONSEQUENCE OF (c) Parkinson Disease								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Bleeding Ulus with Sepsis - Pneumonia								
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to 8-18 , 19 86 , that (we) last saw the deceased alive on 8-14 , 19 86 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.								
22b. SIGNATURE Henry Burke		DEGREE	ATTENDING PHYSICIAN ✓	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 8-18-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry Burke		22e. ADDRESS La Plata, Md. 20646						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-22-86	23c. NAME OF CEMETERY OR CREMATORIAL Resurrection	23d. LOCATION CITY OR TOWN Clinton	COUNTY	STATE			
24. FUNERAL DIRECTOR NAME Huntt Funeral Home	P. O. Box 156 ADDRESS Waldorf, Md. 20601	25a. DATE RECD. BY REGISTRAR AUG 21 1986	25b. REGISTRAR'S SIGNATURE John Huntt					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 4 AND 25 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 IF YOU WANT TO BURN, Cremation, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23105 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <i>Alden</i>	MIDDLE <i>B</i>	LAST <i>Fish</i>	2a. DATE KNOWN OF ESTI- MATED			MONTH <input checked="" type="checkbox"/> 8	DAY <input type="checkbox"/> 25	YEAR <input type="checkbox"/> 1986	2b. HOUR <input type="checkbox"/> 20 27 M	
3. SEX <i>M</i>	4 RACE <i>W</i>	5 DATE OF BIRTH MONTH DAY YEAR <i>12 23 49</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>36 yrs.</i>	7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN			9c. DATE PRONOUNCED DEAD			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Rhode Island</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9d. BALTIMORE CITY OR COUNTY OF DEATH <i>Charles</i>					
10. CITY OR TOWN OF DEATH <i>La Plata</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Physicians Memorial Hospital</i>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Active Duty</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>US Navy</i>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>Prince George</i>		13c. CITY OR TOWN <i>Laurel</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <i>9065 G No. Laurel Rd.</i>				
14. FATHER'S NAME FIRST <i>Alden B. Fish</i>		MIDDLE <i></i>	LAST <i></i>	15. MOTHER'S MAIDEN NAME FIRST <i>Muriel</i>			MIDDLE <i></i>	LAST <i>Blaisdell</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>yes</i>		16b. SOCIAL SECURITY NO. <i>037-32-7871</i>			17. INFORMANT <i>Dorothy A. Fish; 9065 G No. Laurel Rd.</i>			ADDRESS <i>Laurel, Md.</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Minutes</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 _____													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												DATE SIGNED <i>8/25/86</i>	
ACTUAL SIGNATURE <i>H. M. Mahon-Haft</i>			TITLE (SPECIFY) <i>M.D.</i> <i>Charles C. Haft</i> MEDICAL EXAMINER										
EXAMINER'S NAME (TYPE OR PRINT) <i>Howard Mahon-Haft</i>			ADDRESS 701 Charles St.; LaPlata, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>8-29-86</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Elm Grove Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Mystic</i>			STATE <i>Conn.</i>	
24. FUNERAL DIRECTOR NAME <i>Marshall's Funeral Home</i>			25a. DATE REC'D. BY REGISTRAR NAME <i>Jane Darden Redden</i>									ADDRESS <i>4217 9th St NW: Washington, D.C.</i>	
BP _____			25b. DATE REC'D. BY REGISTRAR NAME <i>SEP 09 1986</i>									ADDRESS <i></i>	
DHMH - 17 (VR A15 ME (5)) 20M 4/82													

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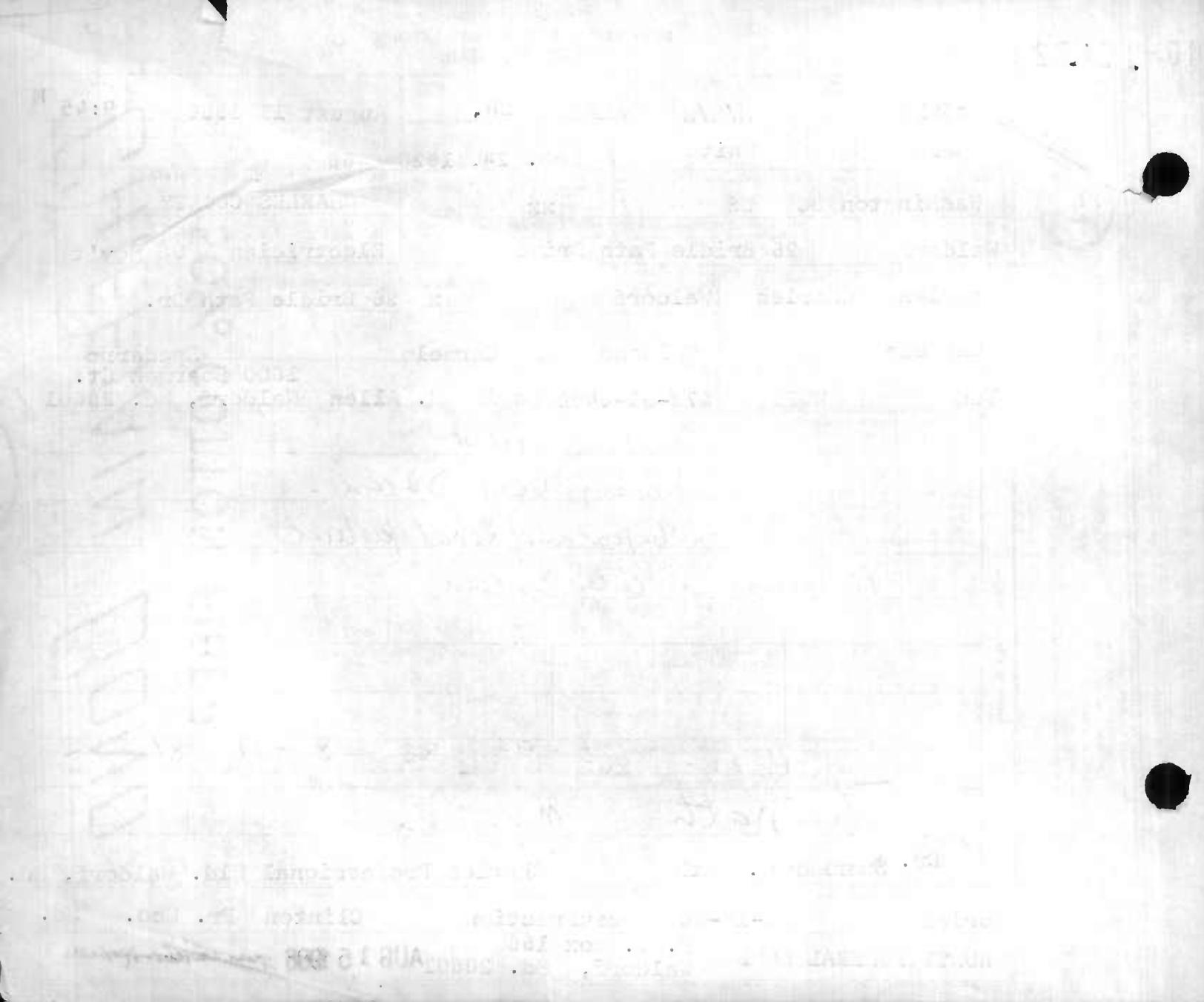
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, or by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
 IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified within 24 hours after death.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6	2	3	1	0	6				
												REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR									
JOSEPH			N/M/N	GALEANO	SR.	August 11 1986						9:45 AM									
SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS									
Male		White		Month Day Year Feb. 24, 1920			66			MONTHS	DAYS	HOURS	MIN.								
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Washington DC		US								CHARLES COUNTY											
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Waldorf		96 Bridle Path Drive										Electrician			US Gov't						
13a STATE Maryland												13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 96 Bridle Path Dr. 208601		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST						
Carmela						Galeano			Carmelo			Spadarro									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
Yes			WWII			579-03-8408			Regina M. Allen			1600 Boarman Ct.			Waldorf, Md. 20601						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
(a) <i>Cardiac arrest</i>																					
{ DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Heart Disease</i>																					
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Diabetes and Renal failure</i> .																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Peripheral Vascular Disease</i>																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>6-26-86</u> to <u>8-11-86</u> , that (I) (we) lost saw the deceased alive on <u>6-26-86</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.																					
22b. SIGNATURE <i>S. Rath</i>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Shankar G. Rath			22e. ADDRESS Charles Professional Bld. Waldorf, Md.																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-14-86			23c. NAME OF CEMETERY OR CREMATORIAL Resurrection			23d. LOCATION CITY OR TOWN Clinton			COUNTY Pr. Geo.			STATE Md.						
24 FUNERAL DIRECTOR HUNTT FUNERAL HOME			P. O. Box 156 ADDRESS Waldorf, Md. 20601			25a. DATE REC'D. BY REGISTRAR AUG 15 1986			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove the first two pages. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other findings, or if item 20 shows any disease, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										6	23	01					
										REG. NO.							
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			Charles Calvin Gray						8/29/86			20:29 PM					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Male			BLACK			12 17 38			47			YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
WASHINGTON, D.C.			UNITED STATES						CHARLES COUNTY			MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
LAPLATA			PHYSICIAN MEMORIAL HOSPITAL			ROOFER			GOVERNMENT								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS / ZIP CODE							
MARYLAND			CHARLES			MARBURY			ROUTE 224/20658								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
EARL NATHANIEL GRAY			CONSTANCE SIMMONS														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
NO			219-34-9490			CONSTANCE MILSTEAD			MARBURY, MARYLAND								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
CARDIAC ARREST																	
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF TONSILS																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																	
DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCE STAGE.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from 5-7-1986 to 8-1-86, 1986, that (I) (we) last saw the deceased alive on 8-1-86, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Kaur M. Mathur MD										22c. DATE SIGNED 8/20/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
KRISHAN M. MATHUR			17 Marshall Rd., Waldorf, Md. 20601														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 9-2-86			23c. NAME OF CEMETERY OR CREMATORIUM St. CHARLES			23d. LOCATION CITY OR TOWN GLYMTONT			COUNTY CHARLES		STATE MD.			
24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME										25a. DATE REC'D. BY REGISTRAR SEP 4 1986				25b. REGISTRAR'S SIGNATURE Sue J. Wilson			
ADDRESS POMONKEY, MD																	

00-15162

(1)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM ENCL. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23108 REG. NO.	
1- STATE REGISTRAR		FIRST			MIDDLE			LAST			2a DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR	2b HOUR	
		RUSSELL			DRAKE			GRAY			8 24 1986	120 ^A M	
3. SEX		4. AMER.		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR	2d. HOUR
MALE		INDIAN		MONTH DAY YEAR		(LAST BIRTHDAY)		MONTHS DAYS		HOURS MIN.		8 24 1986	120 ^A M
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										9. BALTIMORE CITY OR COUNTY OF DEATH	
WASHINGTON, D.C.		U.S.A.										CHARLES	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
LA PLATA		PHYSICIANS MEMORIAL HOSPITAL										CARPENTER	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY			
MD.		CHARLES		MARBURY		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RT.#1 BOX 130 20658		CONSTR. CO.			
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		ADDRESS			
CHARLES		HERBERT				GRAY		LORETTA		REGINA KEHOE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.										17. INFORMANT	
NO		216-88-5163										C. HERBERT GRAY SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gun shot wound to head</i>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)													1 hr.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		Buny Oak Rd		CITY OR TOWN		COUNTY			
		home						La Plata		Charles			
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>H M Mahan Heft</i>		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>			
EXAMINER'S NAME (TYPE OR PRINT) <i>H M Mahan Heft MD</i>		TITLE (SPECIFY) M.D. <i>Charles G</i>		MEDICAL EXAMINER		DATE SIGNED <i>8/24/86</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BP		23b. DATE BURIAL 8-27-86		23c. NAME OF CEMETERY OR CREMATORIUM ST. CHARLES CEM.		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
						GLYMONT		CHARLES		MARYLAND			
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC.		ADDRESS LA PLATA, MD		25a. DATE REC'D. BY REGISTRAR 10/28/1986		25b. REGISTRAR'S SIGNATURE <i>S. L. Ridenour</i>							
20M 4/B2													

0001-00

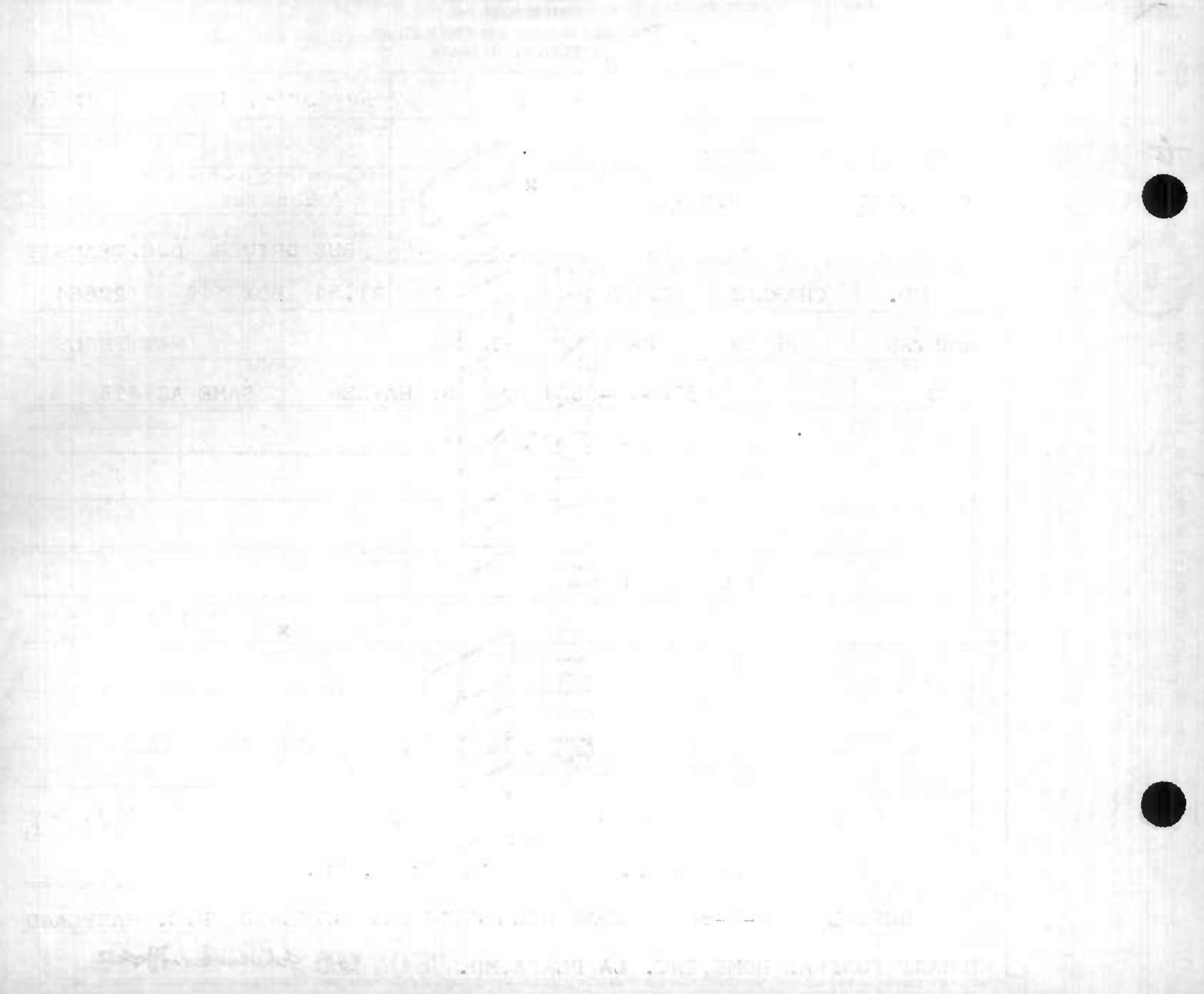
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called to inspect the body.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 23109			
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST Elon	MIDDLE Brian	LAST Hayden	2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
									August 4, 1986			2:15AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		Sept. 15, 1901		84		YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
MARYLAND		U.S.A.				/ Charles							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
La Plata		Physicians Memorial Hospital		BUS DRIVER		D.C. TRANSIT							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13b. STATE MD.		13b. COUNTY CHARLES		13c. CITY OR TOWN NEWBURG		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RT.#1		ZIP CODE Box 149 20664			
14. FATHER'S NAME FIRST WEBSTER		MIDDLE PETER		LAST HAYDEN		15. MOTHER'S MAIDEN NAME FIRST LAURA		MIDDLE		LAST MATTINGLY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		16c. INFORMANT		17. ADDRESS							
NO		578-10-5664		MARY B. HAYDEN		SAME AS #13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a DEMENTIA													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8/1/2, 1986, to 8/1/3, 1986, that (I) (we) last saw the deceased alive on 8/1/3, 1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>D. Seetaramayya Nagula</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/4/86							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Seetaramayya Nagula, MD.		22e. ADDRESS La Plata, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-6-86		23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN SUITLAND		COUNTY P.G.		STATE MARYLAND			
24. FUNERAL DIRECTOR NAME AREHART FUNERAL HOME, INC. LA PLATA, MD. ADDRESS AUG 07 1986													
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>Juliann Anderson-Poole</i>													



00-81750

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM A.M. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23110	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR	
Louise			Benn	Hitchcock	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	8	28	1986	M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR	
Female	White	Nov. 2, 1926	59 yrs.	MONTHS	DAYS	HOURS	MIN	8	28	1986	A.M.		
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Delaware			U.S.A.						Charles County				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
LaPlata			Physicians Memorial Hosp.						Homemaker			N/A	
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				
Maryland			Charles		Waldorf		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Hwy 228, Box 212A 20601				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
Francis			A	Benn	Evelyn				Jane	Lacy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			N/A			Husband			John A. Hitchcock Same as 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>under-</u> lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?				
									<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <u>Driver of auto/multiple vehicle collision.</u>							
9:01 AM 8-28- 1986													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
			road			Rt. 228			Waldorf	Charles	MD		
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u> TITLE (SPECIFY) <u>M.D.</u> Assistant MEDICAL EXAMINER												and in my opinion	
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED	
Dennis F. Smyth, M.D. 111 Penn St., Balto., MD 21201												8-29-86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY	STATE
Burial			9/2/86			Druid Ridge Cemetery Baltimore						Md.	
24. FUNERAL DIRECTOR NAME			ADDRESS			P.O. Box 156			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE	
Huntt Funeral Home, Waldorf, Md. 20601									SEP 2 1986			<u>Richard Pendleton</u>	
DHMH - 17 (VR A15 ME (5))													

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR		23111		REG. NO.							
I. DECEASED NAME (TYPE OR PRINT)		FIRST Kenneth	MIDDLE	LAST Hoeft	2a DATE KNOWN OF ESTIMATED DEATH MATED	MONTH 87	DAY 1986	YEAR 600	2b HOUR 600		
3. SEX Male		RACE White	4. DATE OF BIRTH MONTH 3 DAY 20 YEAR 66	5. AGE (IN YEARS LAST BIRTHDAY) YRS. 66	6. IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN			
7b. PLACE (STATE OR FOREIGN COUNTRY) N.J.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD 87 1986 605			
11. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS OR INDUSTRY Ind.			
13. STATE N.J.		13. COUNTY Hunterdon		13. CITY OR TOWN Glen Gardner		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 31 Bell Ave. 99999			
14. FATHER'S NAME FIRST Richard		MIDDLE Hoeft	LAST	15. MOTHER'S MAIDEN NAME FIRST Jeanette		MIDDLE Perry	LAST				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		16c. ADDRESS 155-01-3592		17. INFORMANT Bernice M. Hoeft		ADDRESS 31 Bell Ave. Glen Gardner N.J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF _____ Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. _____ (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>H. M. Maher</u> NO										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
EXAMINER'S NAME (TYPE OR PRINT)		TITLE (SPECIFY) M.D. Charles G. MEDICAL EXAMINER								DATE SIGNED 8/1/86	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 9-4-86		23c. NAME OF CEMETERY OR CREMATORIAL Lansdale Crematory		23d. LOCATION Lansdale Montgomery Pa.					
24. FUNERAL DIRECTOR NAME Robert J. Crouch		DATE REC'D. BY REGISTRAR SEP 4 1986								25b. REGISTRAR'S SIGNATURE <u>Robert J. Crouch</u>	
999999										BP	
DHMH - 17		VR A15 ME (5)								20M 4/82	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												6 6 2 3 1 1 2		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
DALE					JOHNSON	8-6-86						1:30 AM		
3. SEX			4 RACE	5. DATE OF BIRTH	6 AGE			7 IN YEARS (LAST BIRTHDAY)			IF UNDER 1 YEAR			
MALE			WHITE	MONTH 12 - DAY 1 - YEAR 40	45			YRS.			MONTHS	DAYS	IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
WEST VIRGINIA			UNITED STATES			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CHARLES COUNTY					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Accokeek			HOME 1807 MAPLE LANE			CARPENTER			PRIVATE					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE		
MARYLAND			P.G.			ACCOKEEK						1807 MAPLE LANE / 20607		
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE	LAST	ADDRESS				
FREDERICK				JOHNSON	RUTH					1807 Maple Lane Accokeek, Md.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
NO			368-40-6657			Ellen Johnson								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST														
DOUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF SPINE METASTATIC														
{ DUE TO, OR AS A CONSEQUENCE OF (c) LUNG PRIMARY														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2-10-1986, to 8-5-1986, that (I) (we) last saw the deceased alive on 7-24-1986, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED		
22b. SIGNATURE Krishan M. Mathur												22d. DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			22g. ADDRESS			22h. DATE SIGNED					
KRISHAN M. MATHUR			17 MARSHALL ROAD, MD. 20601			WALDORF			8-6-86					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
BURIAL			8-8-86	Rose Hill			THOMAS			WEST VI.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
THORNTON FUNERAL HOME			POTOMAC, MD.			AUG 08 1986			Julia Darden-Bader					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed without reponed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO. 23113			
1. FOR STATE REGISTRAR		I. DECEASED NAME FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Susie L. Johnson			August 16, 1986		110 A.M.	
3. SEX F		4. RACE BL		5. DATE OF BIRTH MONTH 10 DAY 9 YEAR 09		6. AGE (IN YEARS LAST BIRTHDAY) 77 76 YRS		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY MD		7b. CITIZEN OF WHAT COUNTRY USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County		
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IE NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center		12a. USUAL OCCUPATION CUSTODIAN		12b. KIND OF BUSINESS OR INDUSTRY PRIVATE		
13a. STATE MD		13b. COUNTY Charles		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box 902 La Plata MD 20646		
14. FATHER'S NAME FIRST Wesley		MIDDLE Lyles		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE Elizabeth		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 220-26-4851		17. INFORMANT Phillip L. Johnson		ADDRESS P.O. Box 902 La Plata, Md. 20646		
18. CAUSE OF DEATH Enter only one cause per line for item (b), and (c). PART I. DEATH WAS CAUSED BY Metastatic Cancer of Uterus & Bladder IMMEDIATE CAUSE (a)								
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY
22a. I certify that (1) this hospital attended the deceased from JUNE 12, 1986, to 8176, 1986, that (1) (we) last saw the deceased alive on 818186, 1986, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body of the deceased.								STATE
22b. SIGNATURE GEORGE H. MATTHEWS		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>
22c. PHYSICIAN'S NAME (TYPE OR PRINT) GEORGE H. MATTHEWS		22d. ADDRESS LAPLATA, MD. 20646,		22e. DATE SIGNED 8/16/86				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-19-86		23c. NAME OF CEMETERY OR CREMATORIUM St. MATTHEWS		23d. LOCATION CITY OR TOWN Newtown		COUNTY Charles
24. FUNERAL DIRECTOR NAME THORNTON FUNERAL HOME		ADDRESS POMONKEY, MD.		25a. DATE REC'D. BY REGISTRAR AUG 20 1986		25b. REGISTRAR'S SIGNATURE		
BP _____								
DHMH - 16 60M 7/84 (VRA 15, 4)								

18010-00

bombed

48-22000-528 100-11-A-101

bombed

00-15832

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23114

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR								
			John	W	Knott	08/8/1986				4:55 P.M.								
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.						
Male		Black		MONTH	DAY	YEAR	76	YRS.										
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		USA						Charles										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY										
La Plata		Physicians Memorial Hospital			Farmer			Farming										
13a. STATE 13b. COUNTY		13c. CITY OR TOWN		14d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE											
Maryland		Charles		14d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Routed Box 240 20622											
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS								
Fenwick			Knott	Mary			214-26-5711			Agnes V. Knott SAA								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
(YES, NO, OR UNKNOWN)		214-26-5711						Hemorrhage massive lung left										
								Rupture aneurysm aorta only										
								antherosclerosis										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)													
21d. INJURY OCCURRED <input type="checkbox"/> WHILE AT HOME <input type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 8/5/86 to 8/8/86, that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on 9/8/86, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> did not view the body after death.																		
22b. SIGNATURE		22c. DEGREE			22d. DATE SIGNED													
M.S. COCKBURN MD					AUG 9 1986													
22e. ADDRESS		701 E. Charles St., La Plata, Md. (Physicians Memorial Hospital)																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial		13 Aug 86		ST. MARY'S CATH CH.			Newport, Chas.			Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE										
Martell Adams, Aquasco Rd.					AUG 20 1986			Julie Davidson Pendleton										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/cremation permit. Then please remove carbon paper(s). Pages 1 and 2 should be filed with the 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If Item 21 is marked as "Yes" on any injury, an other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN The [REDACTED] retained by the hospital or attending Physician.

4 hours after death. Page 4 may be

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached from the burial/transit permit. Then please remove carbon paper. Pages 2 and 3 will be filed with the State Dept. of Health and Mental Hygiene prior to burial, removal, or removal.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	862315
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
CHARLES DAY KYLE						August 6, 1986				2:48A M	
3a SEX Male		4 RACE Caucasian		5 DATE OF BIRTH Month Dec 8, 1920 Year			6 AGE (IN YEARS LAST BIRTHDAY) 65 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Virginia		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Charles			MD.	
10. CITY OR TOWN OF DEATH Bryans Road			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home 100 Strawberry Dr.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician			12b KIND OF BUSINESS OR INDUSTRY U.S.Gov		
13a STATE Maryland			13b COUNTY Charles		13c CITY OR TOWN Bryans Rd.		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS / ZIP CODE 100 Strawberry Drive/ 20618		
14. FATHER'S NAME FIRST James MIDDLE H. LAST Kyle			15. MOTHER'S MAIDEN NAME FIRST Willie MIDDLE Mae LAST Hilton								
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 1940-1945 234-22-8562			17. INFORMANT Mary Agnes Kyle			ADDRESS -same as #13-		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LUNG CANCER, METASTATIC										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a ARTERIO SCLEROTIC HEART DISEASE											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERRYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a I certify that (I) (this hospital) attended the deceased from JULY 1986 , to 1982 , that (I) (we) last saw the deceased alive on JULY 1986 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										22c. DATE SIGNED 8/6/86	
22b. SIGNATURE D. Smit DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SEETARANMATA NAGUCHI										22e. ADDRESS Charles Professional Center Box 3 Waldorf, Maryland 20601 Suite 504	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/86		23c NAME OF CEMETERY OR CREMATORY Md Veterans Cem			23d. LOCATION CITY OR TOWN Cheltenham, Pr.Geo., Md				
24 FUNERAL DIRECTOR NAME Hunt Funeral Home		P. O. Box 156 ADDRESS Waldorf, Md 20601			25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE AUG 7 1986 John Anderson, R.N.						

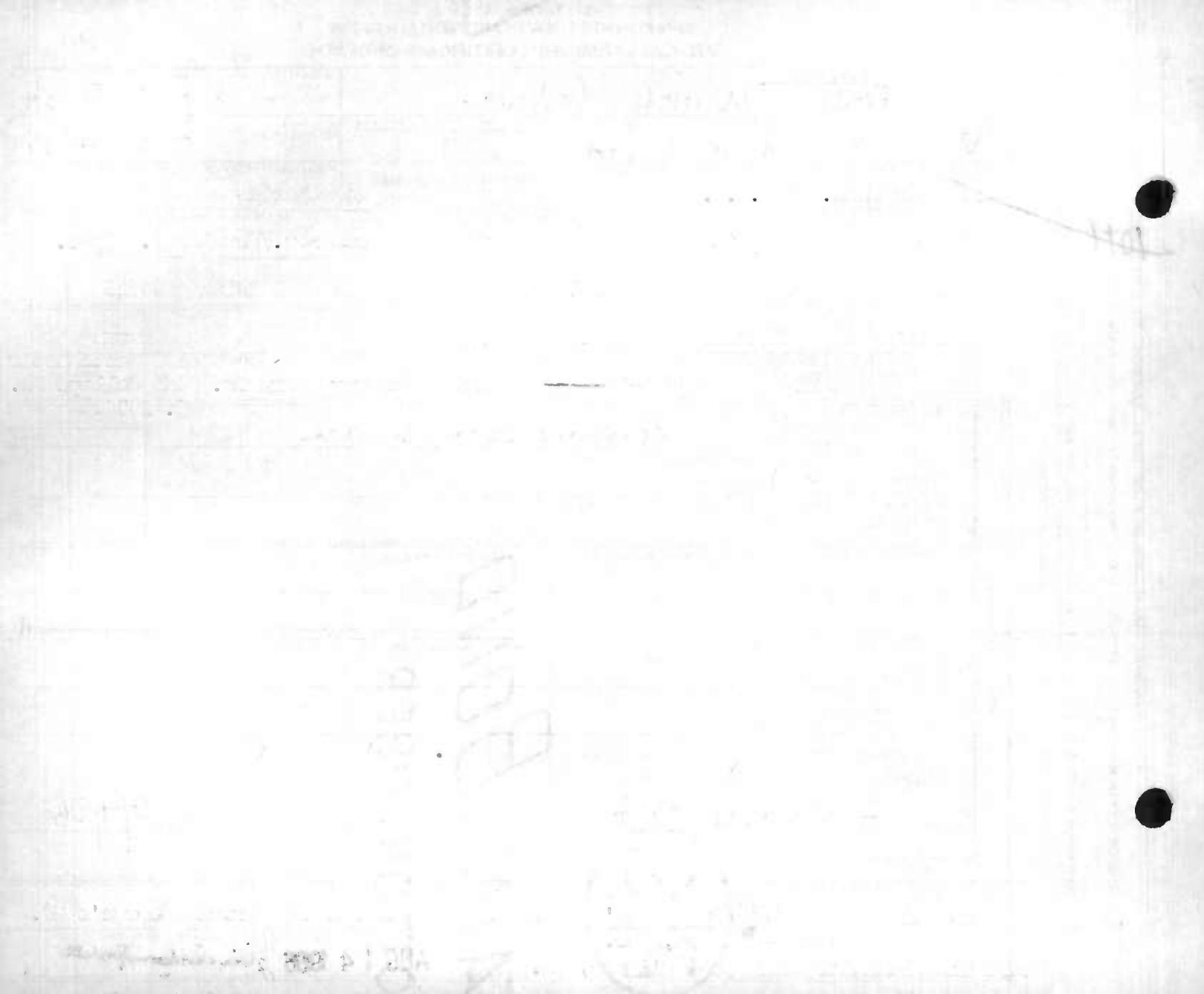
23116
REG. NO.

REG. NO.

00-15280

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DETAILS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO 4 PAGES OF FUNERAL DIRECTOR, PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORNACETAMOL, RETAIN PAGES 1-3 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 200 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DECEASED NAME (TYPE OR PRINT)			Frederick			MIDDLE	LAST	RECD. NO.					
			Fred			W.	I	Lashway					
3. SEX <input checked="" type="checkbox"/> M	4. RACE <input type="checkbox"/> W	5. DATE OF BIRTH MONTH DAY YEAR 11 15 21	6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN	2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8 8 1986 2b. HOUR 05 0 PM							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) West Haven Conn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> XX			9. BALTIMORE CITY OR COUNTY OF DEATH Charles				
10. CITY OR TOWN OF DEATH LaPlata			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mech Egn./Naval Res.			12b. KIND OF BUSINESS OR INDUSTRY Govt.				
13a. STATE Maryland			13b. COUNTY Charles			13c. CITY OR TOWN Cobb Island			14. FATHER'S NAME FIRST MIDDLE LAST Frederick Francis Lashway				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes			16b. SOCIAL SECURITY NO. WWII			17. INFORMANT Anne			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			19c. ADDRESS # 36 Cobb Island 20625			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			ACTUAL SIGNATURE <u>H. M. Maher, Jr.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 08/13/86			23c. NAME OF CEMETERY OR CREMATORIUM Lee's Crematory			23d. LOCATION CITY OR TOWN Clinton			23e. COUNTY Prince George's Md.	
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE <u>J. W. Pendleton</u>							
233 Old Alexander Ferry Road Clinton, Md. 20735			AUG 14 1986										

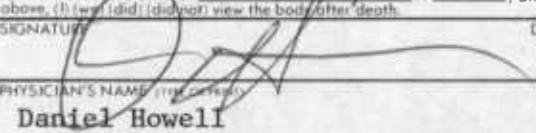


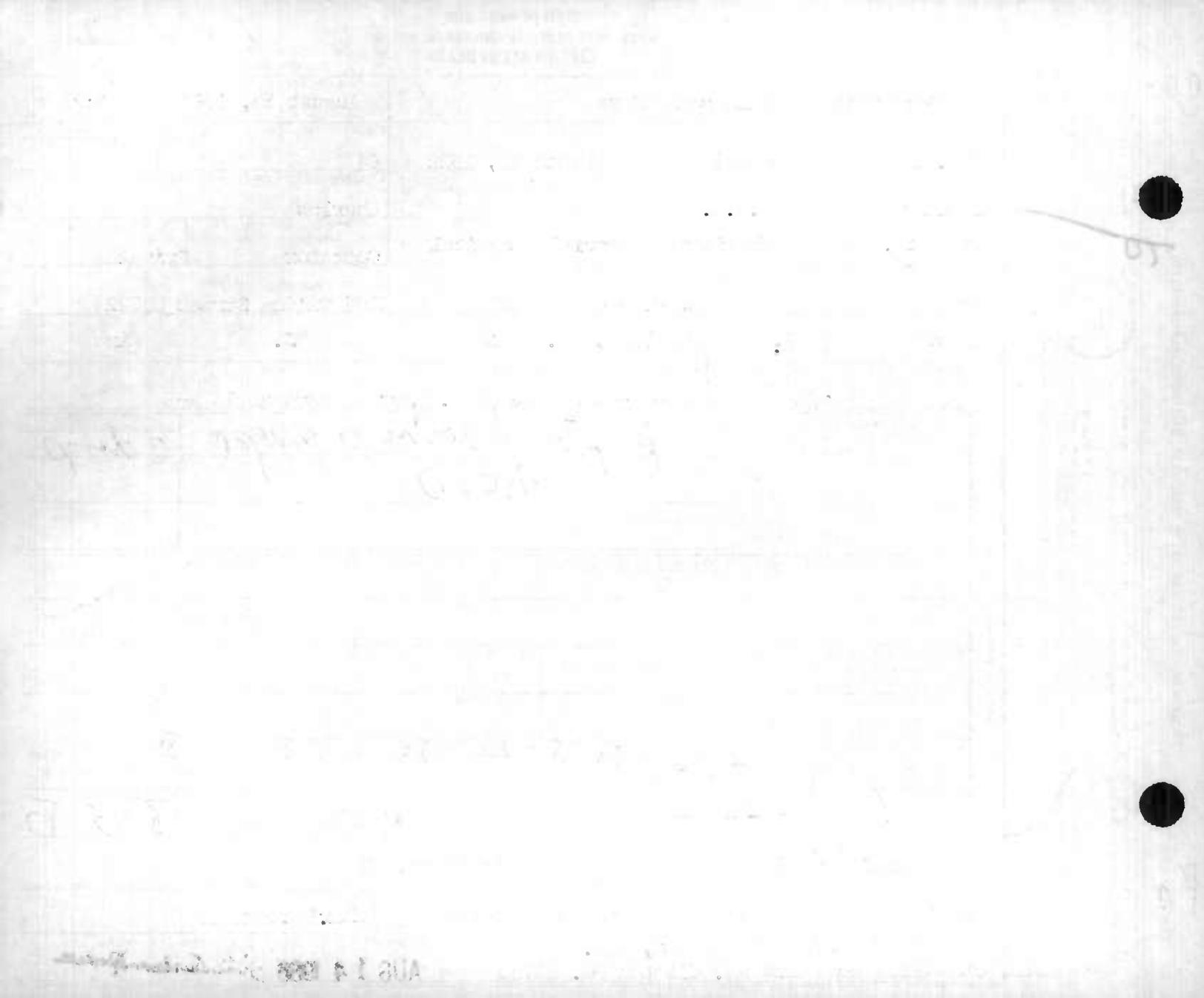
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and certified by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon paper, sign page 2 and file with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked DEATH, Item 22 should say INJURY, or other traumatic event.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6 2 3 1 1 /												
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR August 13, 1986							2b. HOUR 3:25 a m												
1. DECEASED NAME (TYPE OR PRINT) Constance Elizabeth Mays			MIDDLE Elizabeth			LAST Mays		3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR March 25, 1922			6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD														
10 CITY OR TOWN OF DEATH La Plata, MD			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCL FACULTY, GOLF, STREET ADDRESS) Physicians Memorial Hospital			12a USUAL OCCUPATION / (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator			12b KIND OF BUSINESS OR INDUSTRY Private													
13a STATE Maryland			13b COUNTY Baltimore			13c CITY OR TOWN Brentwood			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS / ZIP CODE 3706 Tilden Street 20722										
14. FATHER'S NAME Sidney			MIDDLE L.			15. MOTHER'S MAIDEN NAME Phillips, Sr.			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. N/A			17. INFORMANT James P. Mays			ADDRESS Same as 13 A-E				
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, c and d) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						DUE TO, OR AS A CONSEQUENCE OF (b)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 days													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a I certify that (I) (this hospital) attended the deceased from 8-12-86 to 8-13-86 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																						
22b SIGNATURE 			22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 8-13-86													
22e ADDRESS La Plata, MD																						
23a BURIAL, CREMATION, REMOVAL Burial			23b DATE 08/16/86			23c NAME OF CEMETERY OR CREMATORIAL Oakwood Cemetery			23d LOCATION CITY OR TOWN Charlottesville			COUNTY			STATE VA							
24. FUNERAL DIRECTOR NAME Lee Funeral Home, Inc.			ADDRESS Old Alexander Ferry Rd. Clinton Md. 20735			25a DATE REC'D. BY REGISTRAR AUG 14 1986			25b REGISTRAR'S SIGNATURE 													
DHMH - 16 60M 7/84 (VRA 15, 4) 6633																						



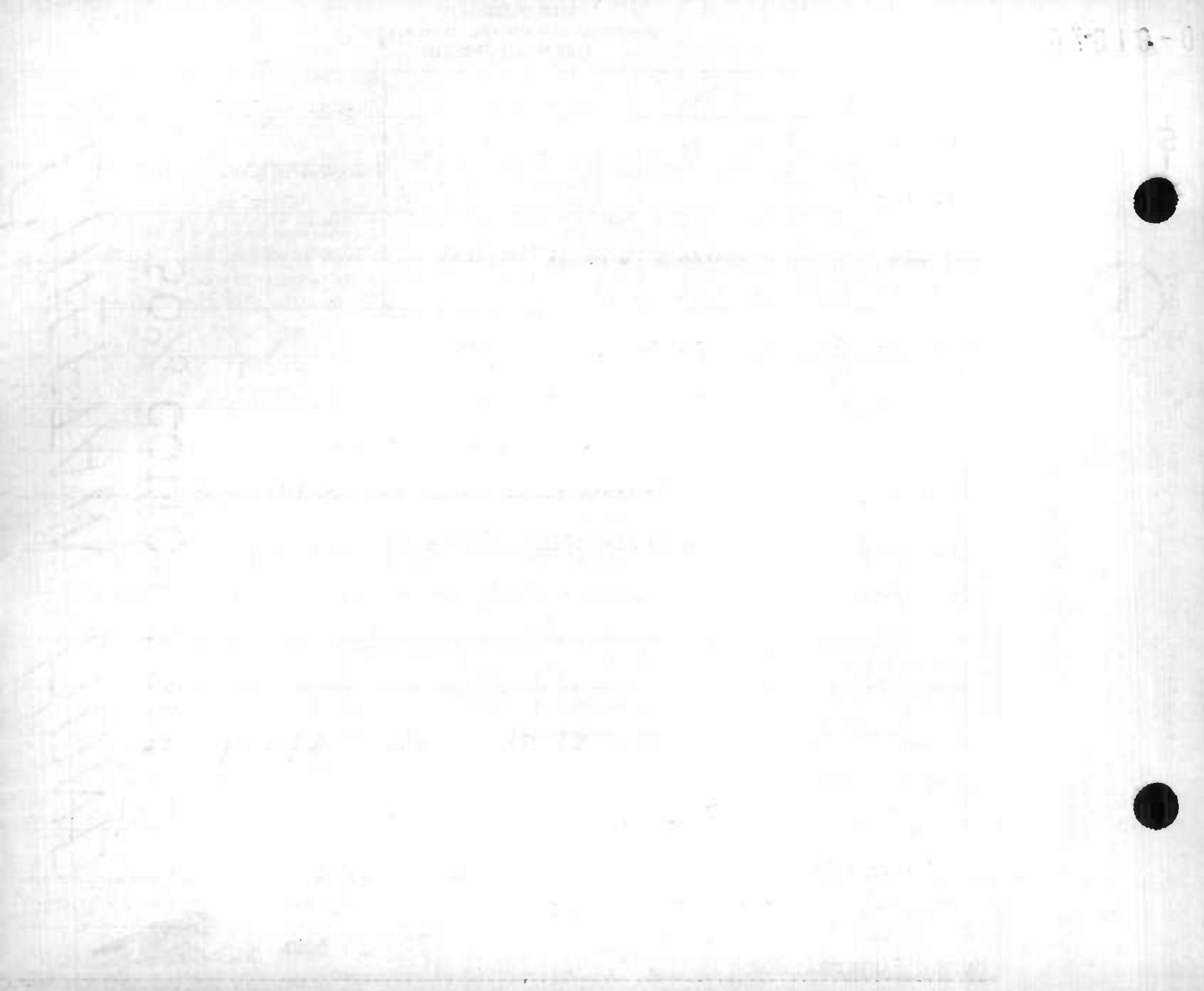
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full, it should be detached for use as the burial-trust permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on Item 10, shows any injury, or other traumatic event, the medical examiner should be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR				
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	August 18, 1986							5:20 PM	
Elia Mae Montgomery														
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)					IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
						March 19 1900		86					YRS.	
7a. BIRTHPLACE COUNTRY Maryland			7b. CITIZEN OF WHAT COUNTRY? US			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.						
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper					12b. KIND OF BUSINESS OR INDUSTRY Domestic			
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2023D Wedgewood Pl/20601					
14. FATHER'S NAME FIRST Francis			MIDDLE Andrew	LAST Montgomery	15. MOTHER'S MAIDEN NAME Rose				MIDDLE LAST Langley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 217-30-1069			17. INFORMANT Alice L. Burch		ADDRESS Rt. 1, Box 457 Hughesville Md. 20637						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio and intestinal obstruction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diverticulitis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART I OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/86</u> , to <u>8/18/86</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <u>Khadar Baig</u>			22c. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>8/18/86</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS Khadar Baig M.D. Waldorf, Md 20601											
23a. BURIAL, CREMATION, REMOVAL (SPEC) Burial			23b. DATE 8-22-86			23c. NAME OF CEMETERY OR CREMATORIUM St. Peters			23d. LOCATION Waldorf County Charles Md.					
24. FUNERAL DIRECTOR NAME Huntt Funeral Home			P. O. Box 156 ADDRESS Waldorf, Md. 20601			25a. DATE REC'D. BY REGISTRAR AUG 21 1986			25b. REGISTRAR'S SIGNATURE Julia Sander Radke					

57516-0

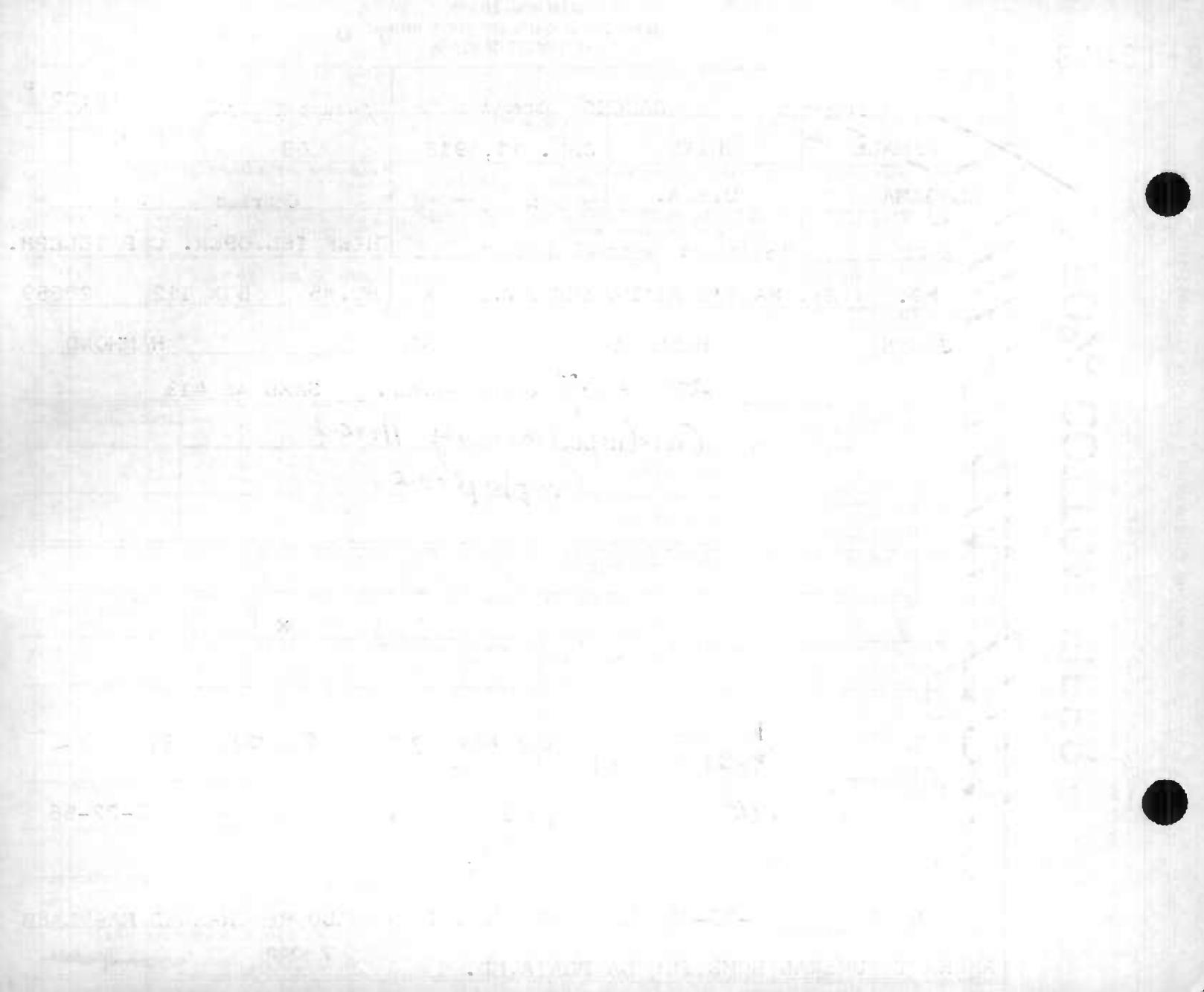


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 56 23119	
1 - FOR STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR P 8:02 M	
			Margaret FRANCES Rowell				August 21, 1986				
3. SEX FEMALE			4. RACE WHITE				5. DATE OF BIRTH MONTH JAN. DAY 11, YEAR 1918			6. AGE (IN YEARS LAST BIRTHDAY) 68 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY ALABAMA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION CHIEF TEL. OPER			12b. KIND OF BUSINESS OR INDUSTRY C&P TELEPH.	
13. STATE MD.			13a. COUNTY ST. MARY'S MECHANICS				13d. INSIDE CITY LIMITS? VILLE NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE RT.#5 BOX 112 20659	
14. FATHER'S NAME FIRST JAMES			LAST HAMMOND				15. MOTHER'S MAIDEN NAME FIRST ROBBIE			LAST HAMMOND	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 255-14-1188				17. INFORMANT JANE ROWELL			ADDRESS SAME AS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>September 19, 75</u> , to <u>8-21-1985</u> , that (I) <u>never</u> lost sow the deceased alive on <u>8-21-1985</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>never</u> did (did not) view the body after death.											
22b. SIGNATURE <u>Bennett</u>			DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-22-86		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Girija Rath M.D.</u>			22e. ADDRESS <u>Waldorf, Md</u>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>8-25-86</u>				23c. NAME OF CEMETERY OR CREMATORIAL <u>HERITAGE MEM. PARK</u>			23d. LOCATION CITY OR TOWN <u>WALDORF</u> COUNTY <u>CHARLES</u> STATE <u>MARYLAND</u>	
24. FUNERAL DIRECTOR NAME <u>AREHART FUNERAL HOME, INC LA PLATA, MD.</u>			25a. DATE REC'D. BY REGISTRAR <u>AUG 27 1986</u>				25b. REGISTRAR'S SIGNATURE <u>John Deardon Pendall</u>				
DHMH - 16 60M 7/B4 (VRA 15, 4)											



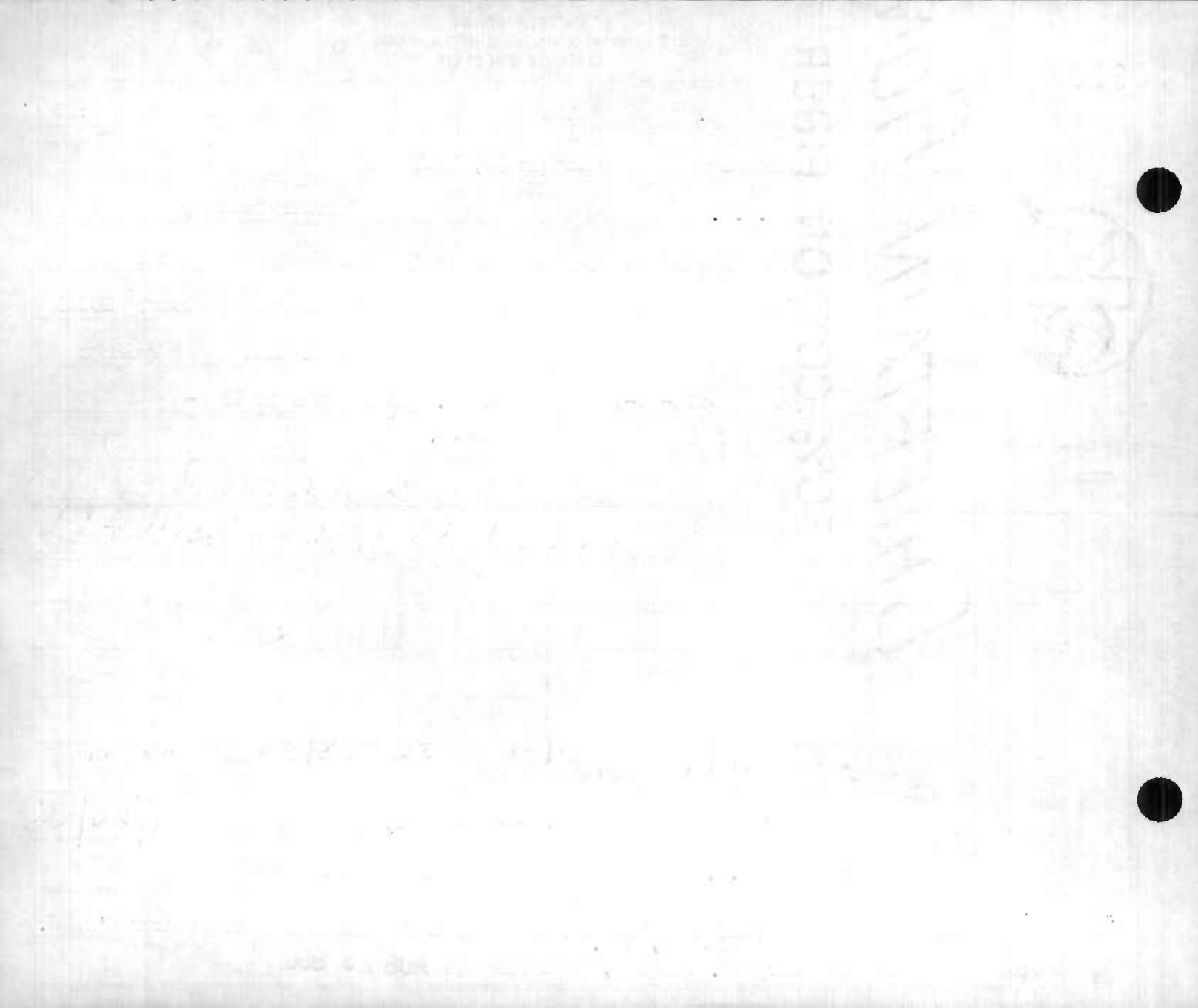
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and countersigned by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 3 and 2 should be held with 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 6 23120		
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	August 20 86			1:15 P.M.			
Sarah H. Selbe												
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR			
Female		Caucasian		October 30, 1927			58		MONTHS DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 24 HRS.			
Maryland		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Charles County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
LaPlata		Physicians Memorial Hospital								Homemaker		
USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION: GIVE RESIDENCE BEFORE ADMISSION										12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE			
Maryland		Charles		Waldorf					3412 Velvet Ash Court 20601			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
Walter				Hook	Ada			Christine Tydings				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			N/A 578-34-7840			Samuel W. Selbe			Same as 13 A-E			
18. CAUSE OF DEATH (Enter only one cause per line for part I, (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Mossaver/Sesamebutin and Demoxing.												
DUE TO, OR AS A CONSEQUENCE OF (b) from, Stomach, condition fibroid tumor												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost												
DUE TO, OR AS A CONSEQUENCE OF (c) wound in joint, Edward Orthopedic												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
		P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) this hospital attended the deceased from 21 23, 19 86, to 21 20, 19 86, that (we) last saw the deceased alive on 21 20, 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE										22c. DEGREE		
										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George Wathen, M.D.										22e. ADDRESS LaPlata, Maryland 20646		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		08/22/86		Resurrection Cemetery			Clinton		Prince George's Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Lee Funeral Home, Inc.		6633 Old Alexander Ferry Rd. Clinton, Md 20735		AUG 25 1986								
DHMH - 16 60M 7/84 (VRA 15, 4)												



00-15712

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

5 6 2 3 1 2 1

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			Elizabeth Pauline Taylor			2a DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 21 HRS HOURS MIN.
Female			White			Sept 7 1909			76 YRS			
7a BIRTHPLACE (STATE OR FOREIGN)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Virginia			USA						Charles County			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUBJECT LINE, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Walney Md			Box 253F Sun Valley Drive			Housewife			Home			
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE			
Md.			Charles						Box 253 20601			
14. FATHER'S NAME			MIDDLE LAST			15. MOTHER'S MAIDEN NAME						
James W. Andrews						Fannie Walker						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			577-68-1499			Mary E Eveson			Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for Part I, II, and III) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) lymphosarcoma												
DUE TO, OR AS A CONSEQUENCE OF (b) Malnutrition												
DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1-10												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2-21-84 to Aug 86, that (I) (we) last saw the deceased alive on 5-18-86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
M. Taleghani, M.D.									8/14/86			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
M.F. Taleghani, M.D.			4467 Old Branch Ave Temple Hills									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION			
Burial			18 Aug 1986			Cedar Hill Cem.			Saultland Maryland			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
Robert E. Wilhelm						AUG 18 1986						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 through 3 may be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked shows any injury, or other traumatic event, the medical

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be recorded within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician (or by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Please sign page 2 and file within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
REG. NO. 00-16693											23122	
1. FOR STATE REGISTRAR			I. DECEASED NAME FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			JEANETTE ELSIE WILLETT			Aug 26, 1986			11:20P _M			
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS			
						Nov 30, 1919			66 YRS			
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.			
10. CITY OR TOWN OF DEATH Indian Head			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) (Home) 1017 Strauss Ave.			12a. USUAL OCCUPATION Home maker			12b. KIND OF BUSINESS OR INDUSTRY Home			
13a. STATE Maryland			13b. COUNTY Charles			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS / ZIP CODE 1017 Strauss Ave. / 20640			
14. FATHER'S NAME FIRST James MIDDLE Kent LAST Willett			15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Pauline LAST Robey									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-58-1042			17. INFORMANT Janet M. Miller			ADDRESS 5611 N.E. 4th St., Ocala, Fla 32670			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						OVARIAN CANCER			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years			
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
YES <input type="checkbox"/> NO <input type="checkbox"/>								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from VAN, 19 86, to 8/26, 19 86, that (I) (we) last saw the deceased alive on 8/1 19 86, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Harvey K. Katzen, M.D.		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			DATE SIGNED 8/22/86				
22d. PHYSICIAN'S NAME (TYPE OF PRINT) Harvey K. Katzen, M.D.		22e. ADDRESS 8926 Woodyard Rd., Clinton, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/29/86		23c. NAME OF CEMETERY OR CREMATORIAL Trinity Mem Gardens			23d. LOCATION CITY OR TOWN Waldorf, Charles, Md.					
24. FUNERAL DIRECTOR Hunt Funeral Home		NAME P. O. Box 156 ADDRESS Waldorf, Md 20601			25a. DATE REC'D. BY REGISTRAR 8/28/86			25b. REGISTRAR'S SIGNATURE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" show any injury, or other traumatic event, the medical examiner may be advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 6 2 3 1 2 3			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR			
Helen Gertrude Winkler						August 14, 1986						8:00 P.M.			
3. SEX Female		4 RACE Caucasian		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
				Jan. 29, 1902			84			MONTHS	DAYS	HOURS	MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Charles			MD.					
10 CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY Homemaker	
13a STATE Md.		13b COUNTY Charles		13c CITY OR TOWN Pomfret			13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS / ZIP CODE Turkey Hill Rd. 20675					
14. FATHER'S NAME FIRST Joseph		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Laura			MIDDLE	LAST	Elizabeth						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. 220-38-1272		17 INFORMANT Hampton L. Peed, Jr., W. Hyattsville,			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MD.								
18 CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebrovascular Accident												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MD.			
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis															
DUE TO, OR AS A CONSEQUENCE OF (c) 															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Diabetes Mellitus, Dementia															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE										
22a I certify that (I) (this hospital) attended the deceased from 8-14 , 19 86 , to 8-14 , 19 86 , that (I) (we) last saw the deceased alive on 8-14 , 19 86 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b SIGNATURE Henry Burke M.D.		22c DEGREE 			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 8-14-86							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Henry Burke M.D.		22e ADDRESS La Plata, Md 20646													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8-18-86		23c NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cem.			23d LOCATION CITY OR TOWN Suitland, Pr. Geo. Md.		25a DATE REC'D. BY REGISTRAR JUN 18 1986		25b REGISTRAR'S SIGNATURE				
24 FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland		ADDRESS													

the "old
naturalized and introduced
species, especially
the *Agave* species.
X 6.2. in flower
TESTIMONIAL ATTACHED

STANISLAWSKI VENET X FLOWERS PLENTY - 10

HOOTING - HOO-HOO-HOO - BROWN SPOTTED - 10

EXTENDED TAIL - LIVELY - COLORFUL - 10

LIVELY - COLORFUL - COLORFUL - 10

EXTENDED TAIL - LIVELY - COLORFUL - 10